CERTIFICATE OF MEDICAL NECESSITY - MOTORIZED WHEELCHAIRS

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 720 (8-2006)

Clear Fields

SECTION A

Certification Date/Type	☐ Initial ☐ Revised
Name	Patient ID

SECTION B - Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

Estimated Length of Need (Number of Months) 1-99 (99 = LIFETIME)

ITEM ADDRESSED	ANSWER QUESTIONS 1, 6 AND 7 FOR MOTORIZED WHEELCHAIR BASE, 1 - 5 FOR WHEELCHAIR OPTIONS/ACCESSORIES.
Motorized Wheelchair Base and All Accessories	1. Does the patient require and use a wheelchair to move around in their residence? ☐ Yes ☐ No ☐ Does Not Apply
Reclining Back	2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day? ☐ Yes ☐ No ☐ Does Not Apply
Elevating Legrest	3. Does the patient have cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered? ☐ Yes ☐ No ☐ Does Not Apply
Adjustable Height Armrest	4. Does the patient have a need for arm height different than that available using non-adjustable arms? ☐ Yes ☐ No ☐ Does Not Apply
Reclining Back; Adjustable Height Armrest	5. How many hours per day does the patient usually spend in the wheelchair? (1-24) Round up to the next hour.
Motorized Wheelchair Base	6. Does the patient have severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition? ☐ Yes ☐ No ☐ Does Not Apply
Motorized Wheelchair Base	7. Is the patient unable to operate any type of manual wheelchair? ☐ Yes ☐ No ☐ Does Not Apply

SECTION C - Narrative Description

Narrative description of all items, accessories and options ordered. If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on SFN 727.

☐ Check here if additional options/accessories are listed on SFN 727

SECTION D - Physician Signature/Date

Signature	Date	(Signature and Date Stamps are not acceptable)